Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING _ IL6008965 08/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3306 SOUTH 6TH STREET ROAD ST JOSEPH HOME OF SPRINGFIELD SPRINGFIELD. IL 62703 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC (DENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY**) Z 000 COMMENTS Z 000 Licensure Annual Survey St.Joseph's Home of Springfield is in compliance with the Shelter Care Facilities Code (77 Illinois Administrative Code 330) for this survey. **Z9999 FINDINGS** Z9999 Statement of Licensure Violations Section 300,690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. This requirement in not met as evidenced by: Based on record review and interview, the facility failed to thoroughly investigate injuries of unknown origin for one of eight residents (R4) reviewed for injuries of unknown origin in the sample of 8. Findings include: R4's Clinical Record has 4 injury incidents of unknown origin between 12/18/2015 and Attachment A 06/13/2016 that do not have investigation documentation which attempted to identify how Statement of Licensure Violations the injury happened or any prevention interventions. 1. R4's Progress Note dated 12/18/15

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois D	epartment of Public	Health			PRINTED: 08/24/2016 FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING;		(X3) DATE SURVEY COMPLETED
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Z9999	Continued From pa	ge 1	Z9999		
	elevator claiming so hallway and that the elevator. There wa and in (R4's) room.	ent came in to hall and got on omebody jumped (R4) in the ey were getting away in the s blood all down the hallway R4's cookies, sandwich and e floor and his left foot was			
	R4 was observed w bloody toes and sta The report docume to person, place, tir	rt dated 12/18/15 documents /alking in the hallway with ited, "Those guys jumped me." ints R4 was alert and oriented ine and situation. The report investigation into how the ingin occurred.			
	"At 2015 observed	ote dated 1/17/16 documents, residents left hand bruised. I) has no idea how it			
	"Found bruise on (first three digits. Als and second finger." stated R4 did not kn was alert and orient situation. The report	rt dated 1/17/16 documents, R4's) left hand on top of the so had a cut between index. The report documents R4 now how it happened and R4 ted to person, place, time and t documents no other ow the injury of unknown origin			
	"CNA (Certified Nur	ote dated 4/10/16 documents, sing Assistant) reported skin ents left hand. Resident states ow it happened."			
	"CNA reported resident Entered room and design and design and design and design are resident as a second are resident as	t dated 4/10/16 documents, dent had blood on (R4's) hand. observed dried blood on top of 'The report documents R4			

Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 1L6008965 08/04/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3306 SOUTH 6TH STREET ROAD ST JOSEPH HOME OF SPRINGFIELD SPRINGFIELD, IL 62703 PROVIDER'S PLAN OF CORRECTION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) Z9999 Continued From page 2 Z9999 stated, "(R4) have no idea how (R4) got it." The report documents no other investigation into how the injury of unknown origin occurred. 4. R4's Progress Note dated 6/13/16 documents, "Noted to have left bruising on left hip area 15 cm | (centimeters) long by five cm wide. No swelling or pain. Resident unsure how happened." R4's Incident Report dated 6/13/16 documents. "Noted to have light bruising to left hip area 15 cm long by five cm wide, no swelling or pain." The report documents R4 was alert and oriented to person, place, time and situation. R4's incident report documents no other investigation into how the injury of unknown origin occurred. The Facility's undated Resident Abuse Reporting policy documents, "Any person witnessing or suspecting abuse or neglect, including injuries of unknown source ... shall follow the follow the following procedures: Written statements from witnesses...An immediate investigation will be initiated..." On 8/3/16 at 1:15 PM, E2, Director of Nursing, stated there was no other documentation other than the progress notes and the incident report for injuries found on 12/18/15, 1/17/16, 4/10/16 and 6/13/16. E2 stated there were no investigations completed for R4's injuries from 12/18/15, 1/17/16, 4/10/16 and 6/13/16. (B)